OMB Approval: 0930-0169
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PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

STATE: Virginia

FISCAL YEAR: 2001

Three copies of the Annual Program Performance Report (PPR) should be submitted no later than January 1 to the attention of:

Protection and Advocacy Section - Room 15C - 21
Center for Mental Health Services
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-3667/FAX (301) 594-0091

Please use the attached glossary and instructions to complete the form. All questions should be addressed to the Protection and Advocacy Section at the above address and telephone number.

PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

FISCAL YEAR: 2001

STATE: Virginia

NAME OF P&A SYSTEM: Department for Rights of Virginians with Disabilities

NAME OF PAIMI PROGRAM (If Different): _____

REPORT PREPARED BY: Heidi Lawyer

TELEPHONE NUMBER: 804-225-2015

E-MAIL ADDRESS: lawyerhl@drvd.state.va.us

DATE SUBMITTED: 12/1/01

SECTION I. PAIMI PROGRAM GENERAL INFORMATION

A. Description of Protection and Advocacy (P&A) System PAIMI Program:

1. Name of PAIMI Coordinator: Jonathan G. Martinis, Esq.
2. Name and Address of designated P&A System:
   a. Main office: **Department for Rights of Virginians with Disabilities**
   202 N. Ninth Street, 9th Floor
   Richmond, VA 232319
3. Satellite office(s) (if applicable): **114 McTanly Place**
   Staunton, VA 24401

B. Governing Board, Advisory Council and PAIMI Staff (on 9/30):

1. Does the P&A have a multi-member governing board? Yes___ No__**X**_
   (If Yes, complete the governing board columns of the Tables in B 3.)
2. Is the Chair of the PAIMI Advisory Council a member? Yes___ No___
   (If No, please explain.)
3. Provide the number for the Advisory Council and the Governing Board as requested in the table below. Indicate the **one primary identification** of **each** member as of 9/30. **Count each member only once**.

	Advisory Council	Governing Board
Total Number of Members on 9/30 of Fiscal Year	**9**	**N/A**
Term of Appointment (Number of years)	**4 years**	
Number of Terms a Member Can Serve	**1 (consecutively)**	
Frequency of Meetings	**Quarterly**	
Number of Meetings Held in the Fiscal Year	**4**	
% (Average) of Members Present at Meetings	**67%**	
Recipients/Former Recipients (R/FR) of Mental Health Services	**5**	
Family Members of R/FR of Mental Health Services	**1**	
Mental Health Professionals	**1**	
Mental Health Service Providers	**0**	
Attorneys	**0**	
Individuals From the Public Knowledgeable About Mental Illness	**2**	

Other Persons Who Broadly Represent or Are Knowledgeable About the Needs of Mentally Ill Individuals		
TOTAL	**9**	

SECTION 1. B (contd.)

4. Does the P&A program utilize volunteers? No

If so, describe how volunteers are used to supplement the activities of the P&A and include activities such as monitoring, fund raising, training, etc.

5. Are PAIMI services and activities to individuals with mental illness and their families supported by funding other than that provided by Federal dollars or P&A program income?
   Yes / X / No / /

If yes, provide a brief, succinct description of any services and activities supported by non-Federal funding or P&A program income. Please, include in this description, any State funded advocacy services provided to the individuals served.

Virginians with Disabilities Act Funding is used to address discrimination against people with disabilities including people with mental illness. Primary activities under this program were employment discrimination and program, facility, service, and public accommodation accessibility under ADA Titles, II and III. Funding from this program in FY 2000 was $237,357.

C. PAIMI Program Staff:

1. Provide the total of staff paid either partially or totally with PAIMI funds or from P&A program income: 11
   a. Of the above total, how many staff are attorneys? 3
   b. Of the above total, how many are non-attorney caseworkers? 4

Ethnicity	**Staff**	**Advisory Council**	**Governing Board**
Hispanic or Latino	0	0	N/A
Not Hispanic or Latino	11	9	
Race	**Staff**	**Advisory Council**	**Governing Board**
American Indian or Alaska Native	0	0	N/A
Asian	0	0	
Black or African American	1	1	

Native Hawaiian or Other Pacific Islander	0	0	
White	10	8	
Gender			
Male	4	4	N/A
Female	7	5	
Total	11	9	

SECTION II. PAIMI PROGRAM PRIORITIES and DESIRED OUTCOMES

Below, list PAIMI program priorities and objectives that were the targets of this fiscal year's program activities. For each priority, provide an example of an individual or systemic case and, if applicable, a legislative activity. **Please include examples of PAIMI Program participation in State mental health planning activities**. Remember case examples should illustrate the impact and/or disposition of PAIMI program efforts. See **Glossary** for definitions.

Provide the following information and complete this form for **each priority** identified for the fiscal year.

1. Priority # P/__/

2. For each indicator of success, provide the following information:
   a. (1.1) Indicator #
   b. Indicator was: /__/Met /__/Partially Met/Continuing /__/Not Met
      If "Not Met" was checked, explain:

      If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

Please select case examples that best reflect the activities related to this priority. Describe the outcome of an activity and write the case example as though you were telling a story. Include the following information in your case narrative(s): what happened (the facts about the situation); why the P&A program became involved; how the P&A program made a difference; and what resulted from this P&A activity? For example, "as a result of P&A intervention, this client lives independently in the community, goes to work every day . . ."

Priority 1

To protect the rights of individuals residing in DMHMRSAS-operated facilities to be free from abuse and neglect by representing the interests of individuals who are at imminent risk or who have been subjected to severe injury and/or death due to (1) physical, sexual, or psychological abuse, including the use of seclusion and restraints and/or lack of access to medication; or (2) physical neglect.

Indicator 1: To protect the legal rights of and represent the interests of individuals who are subjected to abuse or neglect as defined in the Priority.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding an issue related to abuse and neglect.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Information and referral services and technical assistance services are provided to all callers.

1.2. To provide case level advocacy services to persons who meet the established case selection criteria of whom at least 20% shall be members of minority populations.

1.3. To provide legal representation services to persons who meet the case selection and litigation selection criteria of whom at least 25% shall be minorities.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Case level advocacy and representation services were provided to individuals whose issues fell within the priority. The percentage of minorities served by advocacy and/or legal representation under this priority was 24%. Case examples are listed below.

1.4. To conduct investigations of deaths and/or severe abuse or neglect at a mental health facility operated by DMHMRSAS. Where there are findings of abuse and neglect, to pursue appropriate systemic/legal remedies.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Abuse, neglect, and death investigations were conducted at DMHMRSAS-operated mental health facilities. Case examples are listed below and death investigation activity is reported under Section IV of this report.

1.5. To undertake a systemic on-site review at one or more targeted DMHMRSAS facilities of the use of seclusion and restraint.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

The PAIMI team conducted a systemic review of the use of seclusion and restraint at Western State Hospital (WSH) in FY 2000. The staff reviewed seclusion and restraint data and conducted a site visit to the facility in mid-April. With the assistance of WSH staff, all residents who were secluded or restrained during the previous quarter (January to March 2000) were identified, and DRVD interviewed all who were still present at the facility. Relevant records were reviewed and questionnaires for each incidence of seclusion and restraint were completed with the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the

facility director, and others as appropriate. The Western State Report was completed. The analysis found multiple problems with the Western State Hospital's use of seclusion and restraint methods. Specifically, the report found that WSH often used seclusion and restraint before other, less restrictive methods, often used the most restrictive forms of seclusion and restraint before using less restrictive methods of same, often did not inform patients of the reasons they were secluded or restrained and did not inform clients of the behaviors they needed to exhibit before being released. The report was submitted to the director of the hospital and to the Commissioner of DMHMRSAS. The Commissioner responded to the report stating that WSH had adopted new policies and procedures, which would resolve the issues raised by DRVD. Specifically, WSH staff are now required to document their efforts at using less restrictive alternatives to seclusion and restraint, show that seclusion and restraint was used as a last resort, and show that patients were informed of the reasons for being restrained and the behaviors necessary to be released from restraints. A follow up study on the use of seclusion and restraint methods is scheduled for the fall/winter of 2001/02.

Indicator 2: To increase the awareness of facility residents and their families of DRVD services and legal rights through outreach, technical assistance, and training activities.

2.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD who are PAIMI eligible but who do not meet the agency's priorities and/or case selection criteria.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency are provided information, referral, and/or technical assistance services, as appropriate.

2.2. To increase access to and utilization of DRVD services by consumers in DMHMRSAS mental health facilities by meeting with consumers/families, facility staff, and/or human rights staff at DMHMRSAS mental health facilities.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

This objective had several sub-objectives. The sub-objectives related to (1) maintaining an average number of visits to DMHMRAS mental health facilities of four times monthly for each of the three PAIMI advocacy staff or a total of 144 visits for the year; and (2) maintaining contact with the internal human rights advocates to ensure that DRVD information is provided in DMHMRSAS trainings on patient rights in facilities or arranging for DRVD to participate in this training. A total of 139 visits and liaison activities took place to the various mental health facilities. While visiting facilities, the advocates and attorneys routinely meet with residents to discuss the PAIMI priorities and various PAIMI issues. They distribute brochures throughout the facilities, visit the wards to ensure that PAIMI posters are in place, and provide additional posters as needed. They also attended Local Human Rights Committee (LHRC) meetings on a regular basis. They have ongoing contact with the facility directors and internal human rights advocates regarding mutual clients, facility, program, and other issues.

Of significance, the PAIMI advocacy staff established a number of agreements with facilities to provide additional information to patients. Central State Hospital agreed to share DRVD materials in its training for staff and with new forensic admissions. Eastern State Hospital agreed to similarly provide this information with respect to staff training and to provide information to unit social workers. At Eastern State Hospital, agency brochures on seclusion and restraint, discharge planning, and medication are used by the social work department in the hospital's ongoing medication and community reentry groups. A PAIMI brochure is included in each admissions package. Central State Hospital has also agreed to use DRVD materials in ongoing groups and PAIMI brochures are included in admissions packages for new patients.

A PAIMI staff attorney accomplished the following:

- Negotiated an agreement with SWVMHI administrators under which DRVD-provided materials will be placed in training and reference materials which all nursing staff are required to read and sign off on during orientation and annually thereafter. Under the same agreement, DRVD materials will be placed in all patient "Green Books" (individual binders containing informative and workbook materials which consumers are given upon admission to the hospital and which they use frequently (generally once daily)).

- Negotiated an agreement with a state hospital for DRVD to draft and supply materials to be used in required employee orientation and annual in-service training. Subject matter of the materials to include: (1) training on patient rights, (2) explanation of the mission of DRVD and the services it provides, and (3) DRVD contact information (including assurances of confidentiality for whistleblowers). Every hospital employee would be required to participate in the training at least once annually. The project is ongoing. Although the agreement is in place, the materials still need to be developed and delivered to the hospital. Once this has been done, and a short trial period has elapsed, the attorney will pursue similar programs at other facilities.

- The staff attorney is currently in preliminary negotiations with the SVMHI Patient Advocate regarding DRVD advice and possible assistance in the production of a staff training video addressing verbal abuse and related rights issues.

The next sub-objective under Objective 2.2 related to working with the PAIMI Advisory Council to obtain public comment for the development of FY 2002 priorities. After discussion with Council, a series of focus groups were scheduled. Focus groups were held at the following locations: Danville-South Boston Alliance for the Mentally Ill, Central State Hospital, Eastern State Hospital, Psychiatric Rehabilitative Services' Engleside Center, Blue Ridge House in Charlottesville, the Halifax and Danville Chapters of NAMI-VA, Friendship House, Smyth/Washington House, and Powerhouse, Southern Virginia Mental Health Institute, Opportunity Clubhouse in Portsmouth, Catawba Hospital, NVMHI, and its Local Human Rights Committee (LHRC).

DRVD revised its public comment survey (used for all agency programs) based on comments from both of its Advisory Councils. It was mailed to approximately 1,800

individuals on the agency's mailing list. It was also posted on DRVD's web site as a direct input survey to make it easier for consumers to respond. It was also posted on two Internet list serves and handed out by PAIMI staff at various functions they were attending. In addition, staff handed out the survey document to persons with whom they had contact during the quarter. A total of 210 surveys were returned. The public comment survey was also published in the NAMI-Williamsburg Chapter newsletter.

Two public hearings were held in Norfolk on April 16 and in Roanoke on April 23. The public hearings were advertised on the state's VIPnet system and in newspapers throughout the state. In addition, the Notice of Public Hearings was posted on Internet list serves and on the agency's web site. Only four people attended these hearings despite widespread advertisement.

2.3. To inform consumers about DRVD's priorities and to educate clients through distribution of information and training, their rights to consent to treatment, including medication and seclusion and restraints, general rights, and discharge planning.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

PAIMI staff routinely check for availability of brochures and posters in the facility and distribute information. Information is routinely shared through interaction with patients in the facilities during outreach activities. Information on priorities is shared through distribution of PAIMI brochures in the facilities and in discussion during focus groups and training activities. DRVD publications are regularly distributed to patients through their regularly scheduled groups on medications and community re-entry. Objective 2.2 above describes the ways in which PAIMI staff has fostered the distribution of critical information to clients, staff, and family members. In addition to these accomplishments, Catawba Hospital has also agreed to distribute DRVD literature to new admissions and this information has been provided to the hospital. The staff attorney also established and maintained a lobby display for DRVD literature at SWVMHI and negotiated an agreement for improved placement and protection of DRVD posters at that facility.

2.4. To present at least four trainings per PAIMI advocate in facilities, clubhouses, and/or consumer run programs on the rights issues listed in Objective 3.3.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

A total of 11 individual trainings were provided, one of which covered three different consumer run programs. In addition, focus groups used for public comment, not listed here also provided opportunities for education and training. Finally, DRVD held a statewide mental health conference this year. The following specific trainings were provided by advocacy staff during the 2001 fiscal year: (1) Overview of human rights regulations and proposed changes, Central State Hospital; (2) Overview of DRVD, human rights regulations and review process, Eastern State Hospital; (3) Patient access to records and records correction, Central State Hospital; (4) Overview of DRVD/PAIMI, Danville/South Boston AMI-VA Chapters; (5) What DRVD Can Do

for You, consumers, families, and staff of Powerhouse, Smythe/Washington House and Friendship House; (6) Overview of DRVD services and programs, Opportunity House; (7) Your Rights in Discharge Planning, Southwest Virginia Mental Health Institute; (8) DRVD, Who We Are and What We Do, Northern Virginia Mental Health Institute; (9) Patient Rights: Medication and Informed Consent to Treatment, Southwest Virginia Mental Health Institute; (10) Ready for Discharge, Northern Virginia Mental Health Institute; and (11) Patient Access To and Correction of Patient Records, Eastern State Hospital.

Case Examples and Systemic Activity for Priority 1

Example 1. SM was a biologically male transvestite with a history of homosexual rape victimization who had been involuntarily committed to a state hospital. SM's treating psychiatrist psychologically abused her by requiring her to sleep on an open cot in a public area of the admissions unit throughout her multi-week stay at a state hospital (vacant bedrooms were available). SM felt very exposed, insecure, and vulnerable in that situation and suffered extreme anxiety, emotional distress, fear, and sleeplessness as a result of the psychiatrist's actions. SM contacted DRVD and the DMHMRSAS patient advocate after her psychiatrist ignored her repeated requests for more secure sleeping arrangements. When the DRVD attorney confronted the psychiatrist about SM's situation, the psychiatrist readily admitted that he had violated SM's rights and defied DRVD to stop him. Before DRVD could take enforcement action, the psychiatrist discharged SM. The DRVD attorney and the patient advocate then jointly presented SM's complaint to the Local Human Rights Committee (LHRC) for action. The LHRC found the hospital guilty due to the doctor's action; however, the offending psychiatrist had already left the state. The hospital director wrote a letter of apology to SM, and the matter was referred to the medical ethics committee for further action.

Example 2. A female with mental illness in her 40s and a female with mental illness approximately 20 years old were the clients. DRVD received critical incident reports from a state mental health facility regarding two alleged rapes at CSH occurring within a month of one another in the same ward and on the same shift. The first attack was not substantiated by the evidence, but there was evidence to support the second report. DRVD staff investigated the incident and reviewed the hospital's internal investigation process. The perpetrator was charged with forcible sodomy, but for reasons unknown to DRVD, this charge was ultimately dismissed before going to court. The DRVD staff attorney reviewed records, conducted interviews, reviewed the internal investigation reports; attended the preliminary hearing in LM's case; and viewed the facility surveillance videotape from the time of the rapes. The staff attorney attended all criminal proceedings in one case; there were no proceedings in the other case. In coordination with the clients, she drafted and mailed Notice of Claim according to Virginia statute in both cases in order to preserve the rights of both women to sue the facility and the state should either of them choose to do so and counseled both women on the importance of seeking private legal counsel as soon as possible if they choose to proceed with a civil action. DRVD discussed publication of an investigative report with one of the clients. However, the client requested that report not be released publicly even without identifying information. Systemically, the hospital policy regarding room assignments and overnight supervision was changed in response to these two incidents. All female patients are now placed in rooms closest to the nurses' station and there is a staff member stationed in the hallway outside these rooms at all times during sleeping hours. Both cases are now closed.

Example 3. Mr. D. is a long-term patient in one of the state hospitals. He asked DRVD to investigate the circumstances surrounding his assault by another patient and subsequent skull fracture. He had no memory of the assault or the circumstances immediately after. The DRVD advocate reviewed the police and facility investigations and video of the incident. It appears that the other patient came from the restroom and simply walked across the dayroom and proceeded to beat the complainant about the head. Staff responded quickly and separated the two men and got appropriate medical attention for the complainant. At the time of the incident, the ward was staffed within DOJ guidelines and no previous comments or actions indicated that this was to be reasonably anticipated. No neglect was established. The complainant was moved to another ward upon his return from the medical hospital.

Systemic Activity:

A. **Seclusion and Restraint.** Systemic activity regarding the review of Western State Hospital's seclusion and restraint policy and practice was reported above under Objective 1.5.

B. **Patient Safety Hazards.** A PAIMI attorney conducted a systemic review of seclusion facilities and policies in use at Southwestern Mental Health Institute (SWVMHI) as related to patient safety hazards. The PAIMI attorney reviewed the SWVMHI and DMHMRSAS seclusion policies, which were in force at the time, and conducted visits to SWVMHI in November and December 2000. The PAIMI attorney analyzed the collected data and concluded that SWVMHI's seclusion facilities and policies did not present a safety hazard to patients. The PAIMI attorney concluded that SWVMHI's requirement that patients be constantly attended at all times while in seclusion was particularly helpful in increasing the safety of secluded patients, and he began advocating to the directors of other hospitals that they adopt the policy as well. No written report was prepared because, in January 2001, DMHMRSAS issued a statewide Departmental Instruction effectively adopting SWVMHI's policy.

C. **Critical Incident Monitoring.** As a result of the new legislation passed by the FY 2000 General Assembly, the DRVD Director continued to receive notification of deaths and critical incidents through this fiscal year. This activity, directly related to protection against abuse and neglect per Priority 1, has its own Priority (3) and is reported there.

D. **Mental Health Planning Council.** A PAIMI advocate serves on the state Mental Health Planning Council (MHPC) and is the Chair of its Advocacy Committee. The mission of the MHPC is to advocate for a consumer and family-oriented, integrated, and community-based system of mental health care of the highest quality. The MHPC reviewed the Federal Block Grant Application, which includes the state's comprehensive mental health plan pursuant to P.L. 102-321. Based on its assessment of its strengths and weaknesses, the MHPC makes recommendations to the Commissioner of DMHMRSAS, the Board, and to the Governor. The Council continuously monitors and evaluates the implementation of the state's mental health plan. This year, the MHPC focused its attention on the proposed human rights regulations, which were released for public comment in the first quarter of the year. The MHPC submitted comments which supported: strengthening the language regarding informed consent, requiring Local Human Rights Committee review of the decision to perform ECT, requiring an appeal process and review of decisions to limit

patient access to his/her own records, and requiring the inclusion of standards for seclusion and restraint.

E. Patient Rights in Forensic Maximum Security Building. Several issues arose with respect to this particular facility setting. First, the PAIMI advocate became aware that the courtyards for the building were not accessible to persons who use wheelchairs. She contacted the Special Assistant to the Director, about the need for ramps to the courtyard. He responded promptly and arranged for the installation of ramps (meeting ADA standards). Second, patients in the building complained that their blinds were always kept drawn shut so that they could not see the out of doors. This is a secure forensic building and the blinds are behind a locked grate and are not controlled by the patients. After discussion with the administration, arrangements were made to ensure that the blinds were adjusted so that the lovers angle upward allowing the patient to see out while preventing someone on the outside from looking in. Patients also complained that they were allowed little time outside except to smoke, and that if you didn't smoke, you were kept inside. This issue was brought to the administration and regular time outdoors was scheduled. Patients now get four 30 minute outdoor opportunities daily. These coincide with smoking breaks but non-smokers are not required to remain in same area with smokers. Finally, the patients in this building complained that they could not have envelopes or stamps for their mail but had to obtain these through staff. In response to the advocate, the administration arranged to begin stocking envelopes and stamps in the patient canteen so that those patients who wish to purchase them on their own could do so. The advocate also discovered that the practice of staff opening patient mail in front of the patient (for security reasons) had not been approved by the hospital's LHRC (Local Human Rights Committee). This was immediately addressed by the administration.

F. Patient Access to Records. A problem with patient access to their records at a state mental health facility was identified. This was discussed with the facility's advocates who also pursued aspects of the issue. In one building, the practice was that when the patient made a request to see his/her records, the doctor had to write an order to allow this. Further, although the statutory standard for denying access is that the doctor determines that access would be physically or psychiatrically damaging to the patient, the actual practice was that access was denied if the doctor thought the patient would get upset and challenge staff. As a result of the intervention of DRVD and the facility's own advocates, the practice has changed. A memo was sent from the director to the key staff directing that they follow the statutory and human rights guidelines in making determinations, that an order is not necessary for the patient access to his/her own chart, and that if the doctor denies access, the order must make it clear why access is denied and be written into the record with other orders so that anyone pulling the chart can easily verify existence of such an order. A workshop on this topic was conducted on September 28.

G. Outreach and Training. Systemic work with respect to expanding outreach to patients in facilities as well as training opportunities for facility staff were discussed above under Indicator 2.2.

H. Legislation. DRVD's comprehensive legislative package passed during FY 2000 and the agency did not introduce any new legislation in the last fiscal year. DRVD did offer comment, through the legislative process, on bills relating to a proposed study on substitute decision-making for persons with mental illness, mental retardation or other disabilities, a

proposed JLARC study on DRVD, and a study of the state's Not Guilty by Reason of Insanity process. DRVD also monitored the status of other bills related to persons with mental illness and provided summary information on the status of these bills to its PAIMI Advisory Council.

Priority 2

To protect the rights of residents of DMHMRSAS-operated facilities who are deemed by their treatment team as ready for discharge to be served in the least restrictive environment, consistent with the community integration mandate of the "Americans with Disabilities Act (ADA)" and the U.S. Supreme Court decision in Olmstead v. L.C.

Indicator 1. To ensure that individuals ready for discharge from state-operated mental health facilities are discharged to the community with appropriate services and supports.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding discharge issues.

1.2. To provide case level advocacy and legal representation services to persons who meet the established case selection and/or litigation criteria of whom at least 20% shall be members of minority populations.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers receive I&R and/or TA services as appropriate.

Case level advocacy and representation services were provided to individuals whose issues fell with the priority. Thirty-eight (38%) percent of persons served were minorities. Case examples are listed below.

1.3. To advocate for the development of a comprehensive state plan to address the delivery of mental health services in the most integrated setting.

Indicator was: / /Met / X /Partially Met/Continuing / X /Not Met
If "Not Met" was checked, explain:

As written, this objective was not accomplished because Virginia does not have a comprehensive state plan, is not legally required to develop one, and does not intend to do so at this time. In the 2001 General Assembly session, the Governor and DMHMRSAS issued a Comprehensive Mental Health Restructuring Plan which would have provided for the eventual closing of almost all state facilities and the discharge of all ready-for-discharge persons into community-based care. The plan met the requirements for an "Olmstead"-type plan. The Comprehensive Plan was defeated by the 2001 Virginia General Assembly. Despite the lack of a plan, DRVD has engaged in significant, successful activity regarding this issue.

During the fiscal year, the PAIMI and DD managing attorneys met monthly with representatives from DMHMRSAS regarding several topics including discharge and discharge planning. The PAIMI managing attorney was briefed on DMHMRSAS' new

discharge procedures for Community Service Boards and DMHMRSAS' new Performance Outcome Management System program, both of which are designed to streamline the ways that persons who are ready for discharge are placed in community settings.

In a joint program with DRVD's Protection and Advocacy for Individuals with Developmental Disabilities (DD) Program, DRVD commenced investigations of four community services boards (CSBs) regarding the expediency and efficacy with which the CSBs ensure that persons who are deemed to be "ready-for-discharge" from state facilities are discharged into community placements. Through these investigations, DRVD identified over 80 persons who have been so deemed but not discharged. DRVD reached an agreement with two of the CSBs, whereby they would provide DRVD with their lists of clients who have been deemed "ready-for-discharge" and supplement those lists regularly. Two CSBs have, thus far, refused. At the time of this report, litigation had been filed against both CSBs. Additionally, DRVD reached an agreement with DMHMRSAS whereby it agreed to take an active role in discharging persons identified by DRVD. Thus far, over one third of the persons identified have been successfully discharged, in less than one month after they were identified. (See additional detail below under "systems work.")

Case Examples and Systemic Activity for Priority 2

Example 1. SC is a woman with mental illness with a long history of hospitalization and unsuccessful placements. At the time SC asked DRVD for community integration assistance, she had been an involuntary resident of a state hospital for almost a year and had been clinically ready-for-discharge for more than six months. The DRVD attorney investigated the situation and determined that the following factors had delayed SC's discharge: (1) failure of the hospital social worker and the CSB case worker to cooperate with one another; (2) SC's guardian's insistence that SC be placed in an adult home (a less restrictive setting was both clinically appropriate and desired by SC), and her refusal to cooperate with or participate in the discharge planning process; and (3) funding and resource limitations inherent in the case. The DRVD attorney began by meeting with the social worker and CSB worker to establish a constructive working relationship with and among them. When the social worker later attempted to revive the dispute, the DRVD attorney reported the incident to the hospital's Clinical Director. This solved the problem. The DRVD attorney subsequently opened negotiations with SC's guardian, bringing her into the discharge planning process and working toward getting her to write her objections and concerns so that they could be satisfied or otherwise dealt with. While this process was ongoing, the DRVD attorney also coordinated with the hospital Reimbursement Office to remove any financial or convenience incentive the guardian might have had for trying to keep SC in the hospital. At the same time, the DRVD attorney pressed the CSB worker to explore creative funding and resource options which could be used to solve the financial, eligibility, and resource shortage problems in this case. As a result, the CSB worker found a Discharge Assistance Project slot for SC and crafted an appropriate written discharge plan for SC (the Plan). The Plan provided for SC to be placed in a supervised apartment, and to receive financial management, outpatient mental health treatment, medication monitoring, and other supports and services that SC would need to live successfully in the community. After obtaining SC's approval to offer the Plan to SC's guardian, the DRVD attorney and the CSB worker met with the guardian and persuaded her to agree to accept the plan. SC was discharged from the hospital on October 2, 2001 and she is presently living

successfully in the community.

Example 2. Mr. X, a 66 year old man, was a resident of a state facility, having been found NGRI some years ago. The court had ordered the development of a conditional release plan. The serving community services board found only one option for him, an adult care residence. Mr. X visited the facility and said that "it wasn't fit for a dog" and that he would rather die in the hospital than live there. His hospital treatment team agreed that the only proffered placement was not satisfactory. He then contacted DRVD. DRVD met with the client, reviewed his records, and asked for a meeting with the client, his family, the treatment team, and the CSB. The CSB said there were no other options available for Mr. X and that there was no money to support any additional services. The advocate contacted the DMHMRSAS central office to clarify statements made by the CSB. Subsequently, substantial additional funds were identified to support an appropriate discharge plan. The advocate and central office representative met with the treatment team and CSB representatives to review a person-centered discharge planning process and identify levels of service needs. Another placement option was located; the client visited the placement and liked it. Subsequently, his family also visited and approved of the placement. Mr. X was discharged and very happy with the placement.

Example 3. The client (LC) was a female in her 30s with a dual diagnosis of mental illness and mental retardation. The client's father called DRVD for help in securing an appropriate and safe discharge. LC had a long history of hospitalizations and failed attempts at community placement which often put her at-risk. The hospital had worked with LC to get her ready-for-discharge and also wanted to be sure that she would be safe and successful. To that end, the hospital staff had developed an elaborate discharge plan that had safety nets and contingency plans in place based on LC's needs. The plan was stalled, however, by the CSB which had ultimate responsibility for discharge. A DRVD attorney spoke with the CSB case manager and director on many occasions and held them accountable for tasks for which they were responsible and the deadlines set by the treatment team for these tasks to be completed. The DRVD attorney also met with LC and kept in close contact with her parents via e-mail and phone as they were traveling during this entire process. The DRVD attorney also worked closely with staff at the hospital including the social workers and the treating psychologist as well as CSB staff. The result was that LC was discharged and after more than six months, is still doing well in her community placement.

Systemic Activity:

1. **Community Integration.** As describe above in Objective 1.3, DRVD began a program to help ensure that persons who are deemed "ready-for-discharge" are promptly and properly discharged into community based settings. DRVD began formal investigations of four Community Service Boards, who are responsible for conducting predischarge planning for patients who are "ready-for-discharge." DRVD demanded that the CSB's give DRVD a list of all of their clients who are deemed "ready-for-discharge." Of the four, two provided DRVD their lists, two refused. Prior to the end of the fiscal year, DRVD prepared litigation against each of the two noncompliant CSBs.

   DRVD compiled a list of approximately 80 persons who were deemed "ready-for-discharge" and presented it to the Commissioner of DMHMRSAS. The Commissioner entered an agreement that DMHMRSAS would become involved in the discharge planning

and expedite, if possible, the discharges of those persons, and any other "ready-for-discharge" persons identified by DRVD. To date, many of the persons identified by DRVD have been discharged.

DRVD entered into an agreement with the Director of Eastern State Hospital (ESH) whereby ESH would forward information regarding DRVD to any person who had been deemed "ready-for-discharge" by ESH and who had not been discharged within 90 days of being so deemed. This will allow patients, who may not be aware of DRVD's services, to contact DRVD for discharge planning assistance.

DRVD entered into an agreement with the Director of Central State Hospital (CSH) whereby CSH would forward information regarding DRVD to any person who had been deemed "ready-for-discharge" by CSH and who had not been discharged within 90 days of being so deemed. This will allow patients, who may not be aware of DRVD's services, to contact DRVD for discharge planning assistance.

A PAIMI attorney served on the Local Human Rights Committee (LHRC) of a state hospital this year. The LHRC devoted substantial effort this year to systemic projects, which were designed to protect patients' discharge and community placement rights. Such efforts included conducting hearings where the hospital director and various other officials were called to testify before the LHRC, holding evidentiary hearings to determine whether the rights of specific patients had been violated due to discharge delays, and petitioning the DMHMRSAS Commissioner and State Human Rights Committee Chairman for changes at the department level. As a result of these projects, the number of patients at the affected state hospital who were not discharged to appropriate placements within 30 days of being found "ready-for-discharge" has been reduced by approximately 60%.

2. **Mental Health Planning Council.** Community integration was also addressed through the Mental Health Planning Council and as noted under Priority 1 above, a PAIMI advocate serves as Chair of the Advocacy Committee of the Planning Council. This year, the MHPC wrote the Commissioner supporting Virginia's full involvement in the federal initiatives to improve integration and particularly, the SAMHSA grant to develop statewide coalitions to promote community-based care.

Priority 3

To monitor the performance of the DMHMRSAS human rights system through ongoing review and analysis of reports on critical incidents and deaths at facilities and to effect systemic reform, as appropriate, through legal and other activity.

Indicator 1. To ensure that incidents of abuse and neglect are properly reported and investigated and that facilities take appropriate remedial action in instances of abuse or neglect. To ensure that allegations of abuse and neglect are properly reported and investigated by primary investigative and licensure agencies.

1.1. To receive, review, and conduct trend and other analyses of critical incidents in order to identify and address systemic problems related to abuse or neglect.

1.2. To follow-up on selected critical incident reports to determine the adequacy of internal DMHMRSAS investigation and remedial action.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

DRVD received and reviewed a total of 365 critical incident reports (CIRs) in mental health facilities during FY 2001. Staff conducted preliminary inquiries on 28 incidents. Four of these were converted to case/investigation status. Twenty-four were closed with no further action required.

As a part of every preliminary and full investigation, DRVD attorneys and advocates request copies of the internal investigation conducted by DMHMRSAS and review the report to assess the adequacy of the investigation and remedial action taken by the department. Beginning in the third quarter of the fiscal year, staff were required to formally document findings on a revised internal critical incident tracking form. Copies of the DMHMRSAS' internal investigations are requested at the outset of each new investigation.

The agency developed a written policy regarding receipt, tracking, inquiry, and follow-up activity relating to critical incidents to ensure that all DRVD staff handle critical incident inquiries in a consistent manner and that inquiries and investigative activity are documented in a standard fashion to facilitate improved reporting and data analysis. This policy was shared with and approved by the PAIMI Advisory Council at its June 2001 meeting. DRVD completed conversion of the CIR database which will allow DRVD to track critical incidents based upon several parameters, including day and month of incident, facility where incident occurred, type of incident, time of day of incident, and whether the person involved had been in a previous critical incident.

As a result of a preliminary inquiry involving a fall, DRVD examined duty rosters and personnel logs as well as the patient's medical records in an attempt to determine whether there is a systemic staffing issue in the facilities on nights and weekends. The staff attorney reviewed the duty rosters for two wards at the hospital for a one-month period. She found significant differences in staffing patterns between weekends, nights, and weekdays, especially in terms of nursing staff. As a result, this issue was adopted as a systemic issue to be addressed in the FY 2002 PAIMI priorities.

Case Examples and Systemic Activity for Priority 3

Example 1. A PAIMI staff attorney followed up on a critical incident report reflecting arm and torso bruising to JK, a minor child who was then residing in a state mental hospital. JK's mother alleged that JK's injuries were the result of abuse by hospital staff. The DMHMRSAS Abuse/Neglect investigators reported that they did not find sufficient evidence to support a finding of abuse. In monitoring the DMHMRSAS investigation, the PAIMI attorney also monitored the witness interviews, reviewed the hospital's records reflecting the incident and the surrounding circumstances, examined JK's chart, separately interviewed JK, his mother, and two physicians, and reviewed the final investigative report. The DRVD attorney concluded that the DMHMRSAS investigation was adequate in scope and depth, that the inferences made were reasonable, and that the conclusions reached were well grounded in the evidence. When the

DRVD attorney reported his findings to the director of the hospital, the director nevertheless agreed to ensure that the staff persons involved in the alleged incident underwent human rights training as a precautionary measure.

Example 2. DRVD received a critical incident report on a 67 year old man who had sustained a fractured leg. There was particular concern as the patient was listed as "non-ambulatory for over three months" due to degenerative joint pain and was recently diagnosed with osteoporosis. DRVD conducted follow-up which resulted in the following findings:

- Medical response to the suspected fracture was prompt and appropriate.
- Internal investigation of incident yielded one staff's comment that the patient had told her "staff beat him up while in the bath tub." This allegation had not been forwarded to the director for external abuse/neglect investigation per policy.
- The term "non-ambulatory" was meaningless in regard to its usage in this patient's chart. In fact, prior to this incident, patient was able to walk but did so reluctantly. He had an unsteady gait but was able to use a walker. He was scheduled for physical therapy but was generally non-compliant because of pain.
- The osteoporosis consult referenced in the follow-up to CIR had not occurred.

Following these findings, DRVD met with the facility risk manager and completed an additional review. As a result, the complaint of abuse was referred for an abuse/neglect investigation. The investigation confirmed that the patient was an unreliable historian who frequently complained of unsubstantiated fractures. He made several statements in regard to this incident, the most likely of which was that he got "tangled up" when he tried to rise from his geri-chair and broke his foot. There was no evidence of any superficial bruising or trauma which might indicate an inflicted injury. The patient had not been in the bathtub in the period immediately prior to the discovery of the fracture. It appears that, as the original report had stated, the actual cause was unknown, but was apparently not inflicted. The Risk Manager used this incident as a tool to support the need for additional training on report requirements and greater accuracy in documentation. The misuse of the term "non-ambulatory" was highlighted. Additionally, the patient got the needed osteoporosis consultation and follow-up treatment. The facility is working to develop protocols to better ensure that consultations occur as planned.

Example 3. DRVD received a critical incident report after the death of GS, a long-term resident of a state geriatric hospital. GS was a male with mental illness and a number of gastrointestinal diagnoses. He was 83. GS had complained of intestinal pain to a nurse at Piedmont Geriatric Hospital (PGH), and when his condition did not improve and he began vomiting, he was transported to the local medical center. There, he was diagnosed with a ruptured colon and underwent emergency surgery. GS never regained consciousness and died the next day. Despite his age, his death was unexpected, and with his sister's agreement, DRVD conducted a preliminary review. The staff attorney met with his sister and while she had no specific concerns regarding his care at the hospital, she was surprised by his death because she had seen him just weeks earlier and "he looked better than he has in a long time." The PAIMI staff attorney visited the facility and spoke to the acting facility director about the case and the internal investigation process. He stated that the internal investigation did not provide any evidence of abuse or neglect.

The PAIMI staff attorney reviewed this report, and found it to be adequate. The staff attorney also reviewed GS's files including the records of the hospital where he had died after surgery for a ruptured colon. The medical and other records include documentation of many years of problems and procedures related to GS's colon. She spoke with a physician at the hospital who saw no evidence that the death was anything other than a medical event, which was neither foreseeable nor preventable. Evidence obtained as a part of the preliminary inquiry indicates that GS's death was from natural causes and not the result of abuse or neglect. A formal investigation was not initiated.

Systemic Activity:

A. Trend Analysis. As noted above, after receiving two CIRs involving very similar injuries from the same hospital during the same weekend, DRVD staff attorney conducted an investigation of both incidents. While there was no evidence of abuse or neglect in the individual cases, the attorney uncovered a more systemic concern: shortage of staff on weekend and overnight shifts. The attorney requested and received copies of the past month's staff assignment sheets for two wards. The data indicated a significant disparity in staffing levels for weekday shifts as compared to weekend and overnight shifts. Most disturbing was the shortage of nursing staff on the weekend shifts. Due to this concern, the DRVD attorney recommended that the PAIMI team consider this issue as a priority for review during the next fiscal year. The team plans to conduct a systemic review of staffing levels in two hospitals over FY 2002.

B. CIR Verification. A PAIMI attorney used a random sampling technique to check the compliance of two state hospitals with critical incident reporting requirements. In doing so, the PAIMI attorney first utilized an informal network of patient contacts and informants to learn of serious patient injuries. This data was then compared with critical incident reports received by DRVD's Critical Incident Coordinator. No omissions were discovered.

Priority 4

To protect the rights of individuals with mental illness residing in hospitals, licensed assisted living facilities, and nursing homes to be free from abuse and neglect by ensuring that the appropriate agencies fulfill any statutory obligations to promptly and thoroughly investigate reports of abuse and neglect and to monitor conditions in those facilities.

Indicator 1. To ensure that allegations of abuse and neglect are properly reported and investigated by primary investigative and licensure agencies.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD who have been or are at-risk of abuse or neglect.

1.2. To refer abuse and neglect complaints to appropriate licensure and enforcement agencies, request and review investigation reports, and conduct follow-up activity, as appropriate.

1.3. To conduct investigations of abuse or neglect when there is risk of or which results in severe injury or death when there is no primary investigative agency. Where abuse or neglect is found, to pursue appropriate systemic or legal remedies.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency receive I&R and/or TA as appropriate. Referral and follow-up were provided when complaints of abuse or neglect were received for which there was a primary investigative agency. Primary investigations were carried out as appropriate. Case examples are below. Thirty-three (31%) percent of persons served were minorities.

Case Examples and Systemic Activity for Priority 4

Example 1. MS was a low-functioning woman with mental illness woman who resided in an adult care residence (ACR) in the community. A relative of MS reported to DRVD that ACR staff were neglecting MS. The relative was particularly concerned that ACR staff did not permit MS to bathe regularly, and that they failed to assist MS in making necessary visits to her physician. The DRVD attorney filed regulatory complaints on MS' behalf with the Department of Social Services (DSS) Licensing and Adult Protective Services divisions. The DRVD attorney requested that DSS report to him the results of any investigation it might make of MS' situation. The DSS investigator arrived at the ACR within 24 hours after the complaint was made. The investigator found that MS had been given an opportunity to bathe (and had actually bathed) at least three times per week over the preceding month, and that the ACR owed MS no duty to provide her transportation service to her doctor's offices (this responsibility was placed on MS' family by contract). The investigator concluded that there was no evidence to support the relative's allegation that the ACR had neglected MS. Based on his analysis of the DSS report, the DRVD attorney concluded that DSS had made a sufficiently prompt and thorough investigation of MS' situation. The DRVD attorney also concluded that DSS' conclusions were consistent with the available evidence and that no remedial or enforcement action was required.

Example 2. A patient at a state-operated facility was taken to a private hospital for treatment of a minor self-inflicted injury. The patient was a voluntary admission to the state facility and was thus assumed to have the capacity to make her own decisions. She went willingly to the hospital but refused treatment when the emergency room physician wanted to give her a shot. She was told that she had no choice and that she would not be allowed to leave. There was no psychiatric evaluation at the medical facility nor any documented assessment of capacity/lack of capacity. Subsequently, she fought staff as they restrained her and treated her over her objection. This issue was particularly important as the nurse involved filed criminal charges against the patient. A complaint was filed with the Department of Health; results of their investigation are pending.

Example 3. MN, a female in her 40s, called DRVD alleging excessive restraint use at a public hospital's psychiatric ward. The DRVD staff attorney assisted MN in following through with her formal complaint to the Center for Quality Health Care Services and Consumer Protection (CQHCSCP), the investigative arm of the Virginia Department of Health. As a direct result of this complaint, CQHCSCP conducted an investigation of the hospital's psychiatric ward and was concerned enough to notify HCFA and JCAHO of their findings. Both agencies then conducted their own inspections which identified many deficiencies. The hospital filed a plan of action to correct these deficiencies; both the findings and the plan of care were highly

publicized in local media. HCFA and JCAHO continue to monitor the hospital's program. DRVD assisted the client in advocating for her own rights as much as possible, but did have several interactions with the manager of the investigations unit at CQHCSCP. The appropriate agencies were involved in this case and their actions were adequate and effective. At about the same time, DRVD also drafted a formal written complaint to CQHCSCP regarding another patient of that hospital who endured excessive use of restraints.

Example 4. DRVD opened an investigation into the apparent suicide of a CSB client. Review of her records indicates that the client had openly discussed her suicidal intentions for at least one year prior to the event, even going so far as to name the bridge off of which she intended to jump. Nevertheless, it appears, the CSB placed her in a program less than one block away from that bridge. In August 2001, she committed suicide by jumping off of that bridge. The investigation is in the preliminary stages, focusing on reviewing the woman's records and the records of the CSB. Witness reviews are pending.

Systemic Activity:

A. Training. A PAIMI attorney conducted a joint training session for the members of two outpatient clubhouses. The subjects taught at the training were (1) the rights of persons with mental illness living in group homes, adult care residences, and supervised apartments, and (2) the availability of DRVD services to refer, advise, and assist clubhouse members in preserving their rights. Thirty-one persons attended the training.

No other specific systemic activity was undertaken under this priority. However, in part, due to DRVD's work under Case Example 2 above, the hospital in question was denied licensure because of the serious deficiencies found in the operation of the ward. In addition, the hospital was inspected by the Center for Quality Health Care Services and the Consumer Protection Division of the Department of Health. They found sufficient deficiencies to refer the case to CMS and JCAHO for their investigation.

Priority 5

To provide advocacy and legal representation to clients in DMHMRSAS facilities regarding lack of informed consent to treatment by the client or by a properly appointed substitute decision-maker.

Indicator 1. To protect the legal rights of persons who have received treatment in the absence of informed consent or a properly authorized substitute decision-maker.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding lack of informed consent or appointment of an authorized representative as defined in the priority.

1.2. To provide case level advocacy and legal representation services to persons who meet the established case selection and/or litigation criteria, of whom at least 20% shall be members of minority populations.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency are provided I&R and/or TA services as appropriate. Case level advocacy and representation services were provided to individuals whose issues fell with the priority. Thirty-one (31%) percent of persons served were minorities. Case examples are listed below.

Indicator 2. To ensure that the human rights regulations being promulgated by DMHMRSAS contain adequate provisions relating to informed consent to treatment and the appointment of properly authorized substitute decision-makers.

2.1. To review and comment to DMHMRSAS on the proposed human rights regulations at all stages of the regulatory process.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

The revised DMHMRSAS Human Rights Regulations were published for public comment on December 4, 2000. DRVD conducted a focus group with the Northern Virginia Mental Health Consumers Association. In addition, DRVD conducted focus groups/workgroups at four state mental health facilities. In these focus/workgroups, patients reviewed the proposed regulations, compared them with existing regulations, and commented on their concerns. The patients' comments were consolidated and submitted to the Director of Human Rights at DMHMRSAS. As noted earlier, a PAIMI advocate chairs the Advocacy Committee of the Mental Health Planning Council which was also active in the public comment process on these regulations. The advocate maintained ongoing contact with the Director of the DMHMRSAS Office of Human Rights regarding concerns about these regulations, particularly those raised by consumers residing in DMHMRSAS-operated facilities.

DRVD comments on the human rights regulations were presented at the Richmond and Roanoke public hearings. DRVD arranged for the Director of Human Rights at DMHMRSAS to present at DRVD's Mental Health Human Rights Conference to provide an update on and overview of the latest version of the human rights regulations. That draft made substantial changes in response to public comment. Many of the areas of concern were addressed. Informed consent was clarified and provisions for "next friends" were also clarified. Some continuing concerns may require a statutory vs. regulatory solution. Nearly all of the changes requested by DRVD via the public comment process were incorporated into the latest draft, which had been expected to go into effect in the summer of 2001. However, associations representing private hospitals and physicians exercised their legal right to stop the regulatory process from proceeding by submitting a petition asking that the regulations be open to additional public comment. The major areas of contention were LHRC review of ECT and provisions requiring informed consent/ appointment of surrogate decision-makers. That time period has now expired and it is hoped that the regulations will soon be final.

2.2. In collaboration with the Mental Health Association of Virginia (MHAV) hold DRVD/MHAV Mental Health Human Rights Conference.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met

If "Not Met" was checked, explain:

The Mental Health Human Rights Conference was held on June 14-15, 2001. There were approximately 50 participants, lower than anticipated considering the substantive program offered and the extensive statewide advertisement of the conference. Most of the participants were professionals. There were some consumers and family members present. The speakers were excellent and well received. Among the speakers were: Winsor C. Schmidt, J.D., LL.M, Washington State University; Mary Ann Beall; Consumer, Laurel Stine, Esq.; Bazelon Center for Mental Health Law; Jonathan Martinis, PAIMI Managing Attorney, DRVD; Paul Cushing, Office of Civil Rights, Richard Redding, J.D. Ph.D., University of Virginia School of Law. The Virginia Institute for Developmental Disabilities (VIDD), Virginia's UAP, coordinated the logistical arrangements for the conference under contract to DRVD, after the Mental Health Association of Virginia told DRVD only six weeks before the conference was to originally to have been held (in October 2001) that it would be unable to fulfill the terms of its contract. The evaluations of the conference were overwhelmingly positive.

Case Examples and Systemic Activity for Priority 5

Example 1. LC was involuntarily committed, via Temporary Detention Order, to Arlington Hospital. While at the hospital, she refused medication. The hospital insisted that it had the right to force medication and treatment upon LC based upon her status as an involuntary admittee. The hospital petitioned the Arlington County Circuit Court for permission to force medication upon LC. The Court agreed and authorized forced medication based upon LC's status. DRVD learned about the case and filed a Petition to Vacate the Court's Order, arguing that LC's status as an involuntary admittee, by itself, did not give the hospital the right to force treatment or medication upon LC. After the matter was briefed and orally argued, the Court granted DRVD's Motion and Vacated its original Order, holding that a hospital must follow the requirements of Code of Virginia §37.1-134.21 prior to forcing treatment or medication upon LC. Subsequently, the hospital, under the threat of a formal investigation by DRVD, entered into a settlement agreement with DRVD where it agreed that it would not force treatment or medication upon any patient without an appropriate court order.

Example 2. BM was involuntarily committed to a hospital and refused medication. The hospital threatened BM with forced medication. BM contacted DRVD. The same day, DRVD contacted the hospital and threatened litigation, citing the decision made in LC's case described above, if it attempted to force medication upon BM. The hospital entered a settlement agreement with DRVD where it agreed not to force medication upon BM without an appropriate court order. Later, under threat of a formal investigation, the hospital entered into a settlement agreement with DRVD that it would not force medication or treatment upon any patient without an appropriate court order.

Example 3. AG was a 33 year old involuntary resident of a state mental hospital. AG contacted DRVD for assistance after hospital staff repeatedly refused to respect her decision not to take psychotropic medications, held her down, and injected her with Haladol. The DRVD attorney responded to AG's request for assistance in less than an hour. After interviewing AG and her psychiatrist, and examining AG's chart, the DRVD attorney determined that AG did not have an authorized representative who could have authorized the injections and that the hospital had not obtained the requisite court order authorizing AG's

psychiatrist to force AG to have the injections despite her objection. The DRVD attorney immediately confronted AG's psychiatrist, educated him on the legal requirements for forced medication, and demanded that he immediately cease and desist medicating AG against her wishes. The psychiatrist agreed to stop giving AG the Haladol injections unless and until he was legally authorized to do so. The hospital later petitioned the court for a medication order, and the DRVD attorney prepared AG's defense. After an extensive evidentiary hearing in which all of AG's rights were fully protected, the court issued the medication order. AG subsequently began taking her medicine. She was quickly stabilized and discharged from the hospital. AG is now living successfully in the community.

Example 4. A male in his 30s (MR) with mental illness heard about DRVD from another patient at the state mental health facility and contacted the PAIMI advocate regarding his medication issue. MR had been arrested approximately two years ago and charged with capital murder and 17 other felonies. Against his will, his attorney requested and received a court order to evaluate MR for competency to stand trial. MR went to CSH, was evaluated, and was found to be incompetent to stand trial. He was then ordered to receive treatment at CSH for restoration of competency. During this restoration period, CSH determined that MR needed psychiatric medication to restore his competency. MR disagreed and said he would not take the medication. The hospital staff told him they would get an order to medicate him against his will, and that medication would be administered IM. Faced with this option, MR stated he would take the medicine orally, but with the understanding that it would be against his will. At this point, he contacted DRVD. The case was transferred to a PAIMI staff attorney who researched the issue of medication administered over the objection of an incompetent defendant for the sole purpose of restoring him to competency to stand trial. This case was especially challenging given the fact that MR faced the death penalty if he went to court and were found guilty. This issue of using medication over objection to restore a defendant's competency to stand trial is a controversial one in the courts. MR had never been diagnosed with a mental illness before this episode; thus, there was disagreement in professional opinion whether he truly had a mental illness at all, and he displayed no dangerous behaviors during his hospitalization. Therefore, the hospital could not successfully argue that they were medicating him not just to restore competency, but also to protect other patients and staff from a potentially violent individual. DRVD was prepared to move forward with a civil case to argue against medicating MR over his objection for the sole purpose of restoring his competency for trial. However, MR's defense attorney did not support DRVD's involvement in the case, and would not support any action to challenge the use of medication over MR's objection. He stated that he had a plan for this case and MR needed to trust him. DRVD attorneys determined that in a capital case, the agency needed to defer to the decision of the defense attorney. The DRVD staff attorney spoke to MR and explained our decision and then closed the case. MR continued to receive psychotropic medication over his objection during his stay at the state mental health facility. His attorney ultimately made a plea bargain and spared MR the possibility of facing the death penalty. MR now resides in a prison in Southwest Virginia.

Example 5. A resident at a state mental health facility complained that the doctor was threatening to give him medication and perform heart surgery on him without his consent. Upon investigation, the advocate found that the patient had no history of mental health problems until they suddenly appeared about a year ago, leading to criminal charges and his hospitalization for determination of competency and determination of mental status at time of the offense. The client refused to talk with the treatment team about his history and refused to allow medical exams. His treating physician was concerned that the sudden onset of apparent

mental illness/dementia in a 54 year old man might be indicative of serious health problems. She also believed that it was important to address potential medical issues prior to beginning a course of anti-psychotics in an attempt to restore him to competency. There was no surgical procedure anticipated at that time. The DRVD advocate talked with the client about these issues and, although he was able to express some level of understanding regarding why the doctor wanted to do tests, he was unwilling to agree. The advocate explained that the doctor would seek a court order to treat him over objection unless he could identify someone that he would like to have act on his behalf to make these decisions (an authorized representative (AR)). He was unwilling to tell the hospital staff anything about his family or friends which might make appointment of an AR possible. Subsequently, the doctor requested a second opinion regarding capacity to make medical decisions. That physician also found the client to be so impaired that treatment over objection was indicated. The two opinions were reviewed by the hospital medical director who then filed a petition with the court requesting that the court order treatment over objection to determine whether medical issues were present. The order was duly entered after a hearing at which the client was represented by counsel.

Systemic Activity:

A. Forced Medication. DRVD entered into a settlement agreement with the Arlington Hospital that the hospital will not force treatment or medication upon any patient without an appropriate court order. This agreement stemmed from a case in which DRVD litigated on behalf of a client who was improperly threatened with forced medication. Later, under threat of a formal abuse investigation, the hospital entered into the settlement agreement with DRVD.

DRVD entered into a settlement agreement with Northern Virginia Community Hospital that the hospital will not force treatment or medication upon any patient without an appropriate court order. This agreement stemmed from a case in which a DRVD client was improperly threatened with forced medication. DRVD threatened litigation and the hospital agreed not to forcibly medicate the client. Later, under threat of a formal abuse investigation, the hospital entered into the settlement agreement with DRVD.

B. Human Rights Regulations. See description under Indicator 2.1.

Priority 6

To improve the effectiveness of legal representation by defense counsel by increasing the level of knowledge and skills regarding the NGRI process in Virginia.

Indicator 1. To educate legal practitioners of the NGRI process in Virginia in order to improve legal representation.

1.1. To provide information and referral and technical assistance to legal counsel in Virginia regarding the NGRI process.

1.2. To develop and implement educational and training activities on the NGRI process for use with and by defense counsel.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

A PAIMI staff attorney provided educational and consulting services to a private attorney who was contemplating using an NGRI defense for his client with mental illness. He has offered similar services to other attorneys. The educational portion of this objective has encountered some difficulties but is proceeding. The plan is for a one-half-day CLE focusing on the mechanics and procedures of an NGRI case. The thrust of the CLE will be to educate criminal defense attorneys that an NGRI verdict is not, necessarily in a client's best interest. Many persons who are found NGRI spend far more time as an "inmate" of a facility than they would have in prison had they been found guilty. Potential speakers have been identified and approached. The PAIMI team has had difficulty identifying speakers for the program but are continuing to work on this. PAIMI staff also plan to draft an article on the potential pitfalls of pleading NGRI in Virginia.

Case Examples and Systemic Activity for Priority 6

Example 1. WC was a male in his 50s. The DRVD advocate was notified by a psychiatrist at a state mental health facility that he was concerned about WC's status as NGRI, as he had been found not competent to stand trial. WC had a long history of psychiatric hospitalizations and substance abuse. In addition to his borderline intelligence, he had also been diagnosed with organic brain dysfunction caused by years of substance abuse. He was arrested last summer and charged with two counts of trespass and one count of property destruction (all misdemeanors). He had no other criminal record. His defense attorney petitioned the court and received a court order to evaluate WC's competence to stand trial. He was evaluated at CSH and found unequivocally incompetent to stand trial. Less than three months later, the judge sent a model NGRI order to the defense attorney and the Commonwealth's Attorney and asked for their agreement. Both attorneys signified their agreement to the order, and a court date was set. There was no mention of WC's competency to enter a plea. WC appeared in court and the NGRI order was entered. WC was then transferred to the maximum security unit at the state mental health facility. The case was transferred to DRVD staff attorney for legal research regarding the issue at hand. DRVD worked closely with staff at the state mental health facility, including the Special Assistant to the Director for Forensic Services, WC's treating psychiatrist (he submitted an affidavit regarding his professional opinion about WC's incompetence), and the psychologist who evaluated WC and found him incompetent to stand trial. DRVD also worked collaboratively with the DMHMRSAS Forensic Coordinator who, before DRVD's involvement, had involved the Attorney General's Office and written to the court on WC's behalf regarding the same issue, but had been unsuccessful in getting the order vacated. DRVD wrote a petition asking the court to vacate the NGRI order as void. The judge agreed with DRVD's argument and vacated the order. WC will undergo another test for competency and his case will proceed accordingly.

Example 2. TG was a man with mental illness residing in county jail pending trial on felony charges. After receiving a request from TG's wife, the DRVD attorney offered (and later provided) TG's public defender with educational, consultative, and advisory services regarding the NGRI process in Virginia, its various implications for TG, and certain other mental health law issues in which arose in TG's case.

Systemic Activity:

This was designed as a systemic priority. There is no additional activity to report.

SECTION III. INDIVIDUAL PAIMI CLIENTS

Provide the number of individual PAIMI clients for the categories that follow. **Count a client only <u>once</u> during each fiscal year reporting period** (even if the client returned for services many times of if many intervention strategies were provided - they are only counted once). Include individuals carried over from the previous year. Do not include individuals represented as part of a group or a legal class action, and individuals who receive only information or referral services.

A. Number of Individual Clients Served with PAIMI Funds.

It is very important to complete each section of this report. **DO NOT leave any blank spaces**. If no clients were served in any category, list zero. Be sure that the total clients served in each sub-category is consistent. The total number of Persons served (A1 + A2) should be the same number for totals in age, sex, and living arrangements.

SECTION III. A: NUMBER OF INDIVIDUAL CLIENTS SERVED WITH PAIMI FUNDS (contd.)

1. Number of clients receiving advocacy at start of fiscal year: <u>51</u>

[This category reflects the number of clients supported with P &A dollars (P&A funding or program income) who had open cases on October 1. Do not report clients who were served with non-federal dollars. Report that activity in Section VIII of this report].

2. Number of new/renewed clients represented during fiscal year: <u>95</u>

[This is the number of clients who had a case opened during the reporting period (after October 1 and before September 30.) Do not report clients who were served with non-Federal dollars. Report that activity in Section VIII of this report].

Total: <u>146</u>

[Add the numbers from items A.1. and A. 2. This total is the number of cases opened and served with P&A dollars (Federal funding) during the fiscal reporting period. It is an unduplicated count of individuals who received individual case representation].

3. If program income or carryover was used to supplement the P&A allotment for the reporting period, estimate the number of individuals served as a result of carryover program income dollars this fiscal year.

   There was no program income in the PAIMI program. Each year, DRVD carries over a certain amount of its previous year grant award. All available funds are utilized to support

advocacy, representation, training and other program activities. Funds are not allocated by client as most of the cost of advocacy services is in the form of staff salaries. It is not possible for us to determine the number of clients served with carry-over vs. current year income.

[Estimate the number of clients served with carryover or program income. This number is needed to demonstrate how program income increases the ability of the P&A program to serve individuals (to further the purpose of the PAIMI Act].

4. The number of individuals who requested individual advocacy **and** who were eligible for services under the PAIMI Act [42 U.S.C. 10801 et seq.] but not 'served' within 30 days of initial contact due to insufficient PAIMI funding or non-priority issues (include individuals who received other services such as information and referral in-lieu): 37

5. Identify populations, advocacy issues and activities (systemic, legislative, educational, training, etc.) that will need to be addressed in the future:

   A. As reported in previous years, community integration of persons with disabilities continues to be a key issue to be addressed in the years to come. This involves the need for substantial reforms of the mental health/mental retardation service delivery system. Currently, community mental health programs (community services boards) are only mandated to provide "emergency" or "crisis" services. There is no statutory or regulatory requirement to provide community-based services to persons being discharged from state facilities and little inducement to return these residents to their communities. An inadequate number of psychiatrists and inadequate medication management programs in local communities have also had negative effects on the success of persons discharged from mental health facilities. Design of a system which provides adequate community-based services, to include housing and treatment, for persons already in the community as well as for those being discharged from state mental health (and mental retardation) facilities is an enormous challenge. DMHMRSAS continues to implement its Census Reduction Plan and DRVD is continuing to pursue activities related to community integration, through individual case representation and through systemic efforts related to DMHMRSAS and local Community Services Board responsibilities.

   B. Protection and advocacy for the rights of persons with mental illness in juvenile justice facilities, jails, and prisons remains an unmet need. The PAIMI program has limited expertise in this area but in FY 2002 has specifically added services to juveniles within its priorities. DRVD will also continue to participate in Juvenile Justice Coalition activities.

   C. There continues to be a dearth of services (institutional and community) for persons who are dually diagnosed as MI/MR, those who have a brain injury, persons with mental illness who are deaf or blind, inmates with disabilities, and persons with autism with significant behavior problems and are inappropriately being served under the mental health system. An accompanying lack of persons trained in behavioral interventions with this population aggravates the difficulties attendant in maintaining individuals in the community or planning and effecting discharges from psychiatric

facilities.

D. There remains a dearth of services for persons who are deaf or blind. Inmates with mental illness are also underserved.

E. Attorneys who represent consumers in commitment hearings and recommitments lack substantive knowledge of mental health law and practice and spend little time with the person they are to represent. Those who practice criminal law frequently see an NGRI plea as a "win" and do not understand nor explain to their clients that commitment as NGRI may subject them to years of hospitalization – stays that may extend long after symptoms of the mental illness are well-controlled with medication. Legislation is needed to address the rights of individuals who plead NGRI, especially the disparity between the term of forensic commitment versus the maximum potential confinement for the underlying criminal charge. Additional NGRI concerns include the fact that hospitals are facing increased numbers of NGRI patients. Some state facilities feel ill-equipped to handle this population and feel that the solution is to transfer the most "dangerous" of individuals to a facility better equipped in terms of services to forensic clients. However this is not always feasible or in the patients' best interest. Often the choice is to receive inadequate treatment or to be inappropriately transferred out of the home community. DRVD is attempting to address this issue, in part, through education of the private bar. However, this objective was not accomplished in FY 2001 year due to reasons explained above and has been carried forward.

F. There is a general lack of affordable residential options for persons with mental illness. Adult care residences are the only option offered to many and in some areas, there are no ACRs that will accept persons with mental illness. The auxiliary grant money that makes ACRs an option for some is not available to support other housing options, such as a shared apartment with supports.

G. Mental health services to children and adolescents are hard to obtain. There are few available psychiatrists with expertise in treating this population. Yet, the trend seems to be to diagnose children with mental illness earlier and to treat these illnesses with psychotropic medications. Virginia's Comprehensive Services Act (CSA) was designed to make options other than placement outside the home available but still serves only a fraction of those needing services. Many children with severe emotional disturbance and/or mental illness end up in the juvenile justice system as a route, albeit inappropriate, of obtaining some level of mental health services.

B. Number of Case Problems of Individual Clients 210

[This refers to the total number of case problems presented at the time the case was opened. *The number may be higher than the total number of clients served by the P&A because each client may have more than one presenting problem to be addressed].

C. Age of Individual Clients

0- 4	0
5- 20	19
21- 59	117
60 - 64	6

65 and over 2

Total Clients 146 *

** Age of two clients unknown*

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in categories A.1 + A. 2 should be equal to the total for C. - *age*].

D. Sex of Individual Clients

Male	87
Female	59
Total	146

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in A.1 + A. 2) should be equal to the total for D. -sex].

E. Ethnic/Racial Background of Individual Clients

The data in this category is self-reported. Please do not question self-reported data. Each client may select one or more categories.

1. Ethnicity:

a. Hispanic or Latino	2
b. Not Hispanic or Latino	144
c. Information not provided	0

2. Race:

a. American Indian or Alaska Native	2
b. Asian	1
c. Black or African American	41
d. Native Hawaiian or Other Pacific Islander	0
e. White	96
f. Information Not Provided	4

+ 2 Hispanic individuals who did not provide additional information regarding race (cited above)

[Clients may select one or more ethnic/racial categories. P&A staff must ask and report this information].

F. Clients' Living Arrangements at Intake

Independent	11
Parental or other Family Home	4
Community Residential Home (e.g.,supervised apartment, semi-independent, halfway house, board & care, small group home 3 or less)	5
Foster Care	0
Nursing Home(includes ICF, SNF, ICF/MR, etc.)	1
Psych wards of general hospitals (public or private) or their emergency rooms	0
Public (State Operated) Institutional Living Arrangement (e.g., hospital treatment center/school or large group home more than 3 beds)	110
Private Institutional Living Arrangement (e.g., hospital or treatment center, school or large group home more than 3 beds)	9
Legal Detention/Jail/Detention Center	3
Prison	3

Homeless 0
Federal Facility (List) 0
Total Client Cases by Living Arrangement: 146

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in A.1 + A. 2) should be equal to the total for F. - Living Arrangements at the time of Intake].

SECTION IV. CASE COMPLAINTS/PROBLEM AREAS OF INDIVIDUAL CLIENTS

Major complaints/problem areas presented by PAIMI clients were addressed through the provision direct client services which are listed in the following charts. Enter the number of complaints addressed by the PAIMI program on behalf of clients in the last fiscal year. Since many clients received PAIMI assistance on more than one complaint, the total number of complaints may exceed the served.

NOTE: DRVD cannot complete the "Outcome" column related to complaint areas. We track overall case outcomes but do not track outcome by CPAs. Previous guidance from CMHS (as with ADD) has been that the "outcome" category related to the overall case. Consistent with this guidance, DRVD chooses the most appropriate outcome or outcomes related to the closure of the case, regardless of how many case problem areas are addressed. We do not at the current time have the capacity to track outcomes by case problem area and our database does not support this structure. DRVD anticipates upgrading its Client Information system in FY 2002. We have developed outcome forms by CPA and beginning in January 2002 will be working with our systems engineer and program staff to determine how we can meet this requirement.

A.1. Alleged Abuse: Number of Complaints/Problem Areas of Alleged Abuse:

Areas of Alleged Abuse	Outcome	# of Complaints From Closed Cases Only
a. Inappropriate or excessive medication		10
b. Inappropriate or excessive physical restraint, isolation or seclusion		6
c. Involuntary medication		0
d. Involuntary ECT		1
e. Involuntary aversive behavioral therapy		0
f. Involuntary sterilization		0
g. Failure to provide appropriate mental health treatment		10
h. Failure to provide needed or appropriate treatment for other serious medical problems		3

i. Physical assault		8
j. Sexual assault		3
k. Threats of retaliation or verbal abuse by facility staff		3
l. Coercion		0
m. Financial exploitation		0
n. Other. **Please describe on a separate sheet. This number should be less than 1% of the total # of abuse complaints. Make every effort to report within the above categories.		
TOTAL (Sum of a. - n.)		44

A. 2. Complaints Disposition: For closed cases, provide the numbers of abuse complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation 8
b. # of Complaints/Problems Withdrawn or Terminated by Client 6
c. # of Complaints/Problem Favorably Resolved in Client's Favor 30
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor 0
e. Total Number of Complaints/Problem Addressed From Closed Cases 44

ABUSE OUTCOME STATEMENT

For each area of alleged abuse, choose one or more outcome statements that either best described or related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the above table A.1.

A. Persons with disabilities whose environment was changed to increase safety or welfare: **6**
B. Positive changes in policy, law or regulation re: abuse in facilities (describe facility where impact was made): **4** (*1 state mental health facility; 3 private hospitals)*
C. Investigations of abuse by the P&A: **17**
D. Validated abuse complaints that have favorable resolution as a result of P&A intervention: **9**
E. Other indicator of success or outcome: **6**

1. *Apology letter from hospital*
2. *Authorized representative appointed*
3. *Client educated about complaint process with Virginia Department of Health*
4. *DRVD staff drafted letter of complaint to oversight agency; educated client about rights*
5. *Based on DRVD intervention, investigation initiated by law enforcement and Social Services*
6. *Issue reported to proper agencies for redress*

B. Alleged Neglect:

1. Number of Complaints/Problem Areas of Alleged Neglect: Failure to Provide For Appropriate:

Areas of Alleged Neglect	Outcomes	# of Complaints From Closed Cases Only
a. Admission to residential or inpatient care facility		1
b. Transportation to or from treatment facility		0
c. Mental health diagnostic or other evaluation (does not include treatment)		1
d. Medical (non-mental health related) diagnostic or physical examinations		2
e. Personal care (e.g., personal hygiene, clothing, food, shelter)		3
f. Personal safety (physical plant and environment)		3
g. Personal safety (client-to-client abuse)		5
h. Written treatment plan		2
i. Rehabilitation/vocational programming		0
j. Discharge planning		29
k. Release from institution		5
l. Other. [Please describe on a separate sheet. This should be less than 1% of total neglect complaints. Make every effort to report within the categories identified above. *Community Services* *Lack of Supervision*		2
TOTAL (Sum of a -l)		53

B. 2. Complaints Disposition: For closed cases, provide the total number of neglect complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined upon Investigation Not to Have Merit 5
b. # of Complaints/Problems Withdrawn or Terminated by Client 5
c. # of Complaints/Problem Resolved in Client's Favor 42
d. # of Complaints/Problem Not Resolved in Client's Favor 1
e. Total Number of Complaints/Problem Addressed From Closed Cases 53

(Sum of a-d Should Equal the Total # of Complaints in Table B.1.)

NEGLECT OUTCOME STATEMENT

For each area of alleged neglect, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column in table - B.1.

A. Investigations of neglect with P&A involvement: **4**
B. Validated incidents of neglect by type: **4**
C. Positive changes in policy, law or regulation regarding neglect in facilities (describe facilities): **3** (*2 state mental health facilities; 1 Community Services Board)*
D. Persons with disabilities discharged consistent with their treatment plan after P&A involvement: **16**
E. Persons with disabilities who had treatment plan that met selected criteria as a result of P&A Involvement: **9**
F. Other outcomes as a result of P&A involvement **6**

1. *Access to facility advocate was obtained*
2. *All hazardous electrical conduits were removed*
3. *Psychotropic meds were discontinued.*
4. *Client participated in discharge plan development*
5. *Issue reported to Adult Protective Services and licensing agency*
6. *Client obtained understanding of NGRI process*

C. Alleged Violation of Rights

1. Number of Complaints/Problem Areas on Protection of Rights:

Areas of Alleged Rights Violations	Outcome	# of Complaints from Closed Cases Only
a. Discrimination in housing		0
b. Discrimination in employment		1
c. Denial of financial reimbursements or entitlements (e.g., SSI, SSDI, Insurance)		0
d. Problems with guardianship/conservatorship		1
e. Denial of information about rights protection or legal assistance		3
f. Denial of privacy (e.g., right to congregate, make/receive telephone calls, receive mail)		2
g. Denial of recreational opportunities (e.g., grounds access, television, smoking)		2

Areas of Alleged Rights Violations	Outcome	# of Complaints from Closed Cases Only
h. Denial of visitors		0
I. Denial of access to records/correction of records		2
j. Breach of confidentiality of records (e.g., failure to obtain consent to disclose)		0
k. Failure to obtain informed consent (may overlap with Involuntary treatment)		13
l. Failure to provide education (consistent with IDEA and state requirements)		2
m. Problems with advance directives		0
n. Denial of parental/family rights		0
o. Problems with consumer finance issues		0
p. Problems with immigration		0
q. Problems with criminal justice issues		1
r. Denial of community habilitation services		0
s. Problems with health insurance/managed care		0
t. Other. [Please Describe on a separate piece of paper) This should be less than 1% of total # of violation of rights complaints. Make every effort to report within the above categories.] 1. *Rights in Institution* 2. *Capacity/Incapacity of Client* **3.** *Denial of post-secondary education*		3
TOTAL (Sum of a. - t.)		30

C. 2. Complaints Disposition: For closed cases, provide the number of rights violations complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation 3
b. # of Complaints/Problems Withdrawn or Terminated by Client 1
c. # of Complaints/Problem Favorably Resolved in Client's Favor 24
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor 2
e. Total Number of Complaints/Problem Addressed From Closed Cases 30

[Items a-d should equal the Total # of Complaints listed above in Table C.1]

VIOLATIONS OF RIGHTS OUTCOME STATEMENTS

For each of the areas of alleged violation of rights, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the table above.

A. Persons with disabilities served by the P&A whose 'rights' were restored as a result of P&A Intervention. **9**

B. Persons with disabilities whose personal decision-making was maintained or expanded as a result of P&A intervention. **23**

C. Policies or laws changed and other barriers to personal decisions making eliminated as a result of P&A intervention. **2**

D. Other outcomes as a result of P&A involvement **4**

1. *Client received independent psychiatric evaluation*
2. *Client discharged*
3. *Client educated about medication/treatment orders*
4. *Client admitted to residential facility*

OUTCOME STATEMENT

For each of the areas of alleged abuse, neglect, or rights violations, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column above.

A. Persons with disabilities served by the P&A whose complaint of abuse, neglect, discrimination of their rights was remedied by the P&A. **31**

B. Persons with disabilities who secured access to administrative and judicial processes as a result of P&A intervention. **18**

C. Persons with disabilities who secured information about their rights and strategies to enforce their rights as a result of P&A intervention. **60**

D. Persons with disabilities who took action to advocate on their own behalf as a result of P&A intervention. **25**

E. Allegations of abuse or neglect that were substantiated by P&A **17**

F. Allegations of abuse or neglect that were not substantiated by P&A **17**

G. Other outcomes as a result of P&A involvement. *Other outcomes were provided in the individual sections on abuse, neglect, and violation of rights.*

SECTION IV. Contd.

5. Intervention Strategies to Address Individual Clients

Complaints/Problems Areas: Enter the number of intervention strategies used to address each client complaint/problem area. A client may have more than one complaint and each complaint may require more than one intervention strategy. The total number of intervention strategies may exceed the total number of clients served. **[Do not report each phone call, letter, meeting, or other action taken on behalf of a client as a separate intervention strategy. Referrals, counseling, and negotiation are considered cumulative processes**]. See Glossary for the definitions of "Intervention Strategies.

Intervention Strategies **See explanatory note below*	Outcome	Number
1. Short Term Assistance:	_____	21
2. Abuse/Neglect Investigations:	_____	9
3. Technical Assistance:	_____	41
4. Administrative Remedies:	_____	25
5. Negotiation/Mediation:	_____	85
6. Legal Remedies:	_____	2
TOTAL # of Invention Strategies [Add items 1. - 6.]	_____	183

[Complete any of the above outcomes that are appropriate. Refer to the data in Table C. 1. to identify completed outcomes. For example, technical assistance (TA) in self- advocacy should result in the outcome " persons who secured information about their rights and strategies to enforce their rights. . . .

NOTE: DRVD cannot complete the "Outcome" column related to intervention strategies. We track overall case outcomes but do not track outcome by CPAs or by intervention strategies. Tracking by intervention strategies does not seem to be a feasible requirement as most cases involve multiple intervention strategies and the result would be a duplicative count. As noted in an earlier section, previous guidance from CMHS (as with ADD) has been that the "outcome" category related to the overall case. Consistent with this guidance, DRVD chooses the most appropriate outcome(s) related to the closure of the case, regardless of how many case problem areas are addressed or how many intervention strategies are provided. We do not at the current time have the technical capacity to track outcomes by intervention strategy or case problem area. DRVD anticipates upgrading its Client Information system in FY 2002. We have developed outcome forms by CPA and beginning in January 2002 will be working with our systems engineer and program staff to determine how we can meet the requirement to track by complaint area. It is unclear how the requirement to track outcomes by intervention strategy could be met. Even following the instructions below, which give some guidance regarding choosing outcomes appropriate to the intervention strategy, would not result in an accurate count. For example, per these

instructions, the number "60" should be entered as the outcome for the Technical Assistance intervention strategy because 60 people received information about their rights. However, this is misleading as some of the 60 people who received information about their rights received case level not technical assistance services. This would be true of all categories and provide data, which lacked integrity.

SECTION IV.

E. DEATH INVESTIGATION ACTIVITIES

1. Number of deaths in residential facilities for individuals with mental illness reported overall, throughout the State. 63*

*Of the 63 deaths, 55 of the individuals who died were geriatric patients.

If information is not available, check here _____ and explain:

2. Number of deaths in residential facilities for individuals with mental illness investigated by the PAIMI program. 3

Describe the nature of the involvement:

1. A DRVD advocate heard that a woman died unexpectedly while a patient at a state mental health facility and contacted the husband for consent to investigate. After reviewing all of the medical records, there was no evidence of abuse/neglect found. A letter so stating was sent to the next of kin.

2. An individual died following an inflicted head injury at a state mental health facility. The advocate completed a chart review with interviews of all involved personnel (except assailant) and found that the facility had resolved areas of concern that may have contributed to a death as a result of patient to patient assault. A letter to the family was sent with findings. A full investigation was not possible due to lack of access to the assailant and his records. A letter to the family was sent so indicating.

3. DRVD was notified of the death of CR by a phone call from NAMI VA. A PAIMI staff attorney completed the investigation and prepared the draft investigative report pending review and findings from a medical expert. The new PAIMI staff attorney took over the investigation. The expert submitted a report in August 2000 which was inadequate and inconclusive. The case is now two years old and without a comprehensive medical review opinion, DRVD can not draw any valid conclusions regarding abuse or neglect. DRVD communicated its factual findings and information to a private attorney who is pursuing a potential civil case on behalf of the estate of CR. The case was closed after the staff attorney spoke to CR's mother about the findings (or lack thereof) of DRVD's investigation and the Managing Attorney shared similar information with the attorney retained by CR's family. DRVD staff offered to assist the private attorney by sharing records with him as authorized by CR's mother, but the attorney never followed through with this request.

Death in a jail

1. A woman died unexpectedly while in the local jail. The autopsy revealed that she had ingested large quantities of her own prescription medication. Jail policy regarding in-processing and response to serious incidents is being investigated. The investigation is ongoing.

SECTION V. INTERVENTIONS ON BEHALF OF GROUPS OF INDIVIDUALS

A. Summary Information

Type of Invention	Potential # of individuals impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy – non Litigation	Exact figures unknown and would be unverifiable estimates. Specific activities undertaken will affect: 80 patients at CSH Max Security Unit 227 patients at Western State Hospital All patients at state mental health facilities who are or will be at some point ready for discharge. 2 current wheelchair users at CSH 30 residents of CSH Bldg. 96 All residents of ESH (approx. 500) 35-40 in CSB	12	0	3
Investigation (Other than Death)	80 patients in max security unit at CSH 500+ persons served through a local CSB.	2	4*	1
Monitoring Services in Facilities**	1,479 Census data at 7 of 10 state MH hospitals*	26	0	2
Monitoring - Court Ordered	0	0	0	0
Class Action Litigation	0	0	0	0
Other	0	0	0	0
Total	1,979 +	40	4	6

**Regarding the four investigations which were "unsuccessful", three were unresolved due to a lack of merit of the claim.*

*** A total of 365 Critical Incident Reports were reviewed in MH facilities. DRVD conducted preliminary inquiries on 28 of these. Four were opened as investigations and/or cases. The 1,479 figure represents the census of the 7 mental health facilities in which preliminary inquiries were conducted. There were no preliminary inquiries undertaken at Piedmont Geriatric, Hyram Davis Medical, or Southwest Virginia Mental Health Institute. Therefore the census of these facilities was not included in the "Potential Number of Individuals Impacted."*

This table captured information on how the P&A program used its Federal funding or program income for non-individual client services. This information was not reflected in previous sections of this report. The activities reported in this table should be linked to the priorities for this fiscal reporting period. The sub-categories listed in the left column of the table (and the numbers for each category) should relate to the narrative section that follows.

Provide at least **one example tha**t reflected the outcome of each sub-category listed in the above. The narrative should briefly describe your PAIMI program activities. Use examples of work that illustrate the impact of P&A program activities. Focus on how these activities made a difference and/or improved the quality of life for your clients. Write your description as if you were telling a story. Include descriptive information on who was involved (the facts about the activity), why the P&A program addressed the issue, how the P&A activities made an impact and, what resulted from this P&A intervention. If program income was used to support any of the above referenced P&A activities, then describe how the program income increased your ability to further the purposes of the PAIMI Act.

1. **Non-litigation Group Advocacy.**
   The following examples were also listed earlier in the report under the relevant Priority.

   A. **Seclusion and Restraint.** Systemic activity regarding the review of Western State Hospital's seclusion and restraint policy and practice was reported above under Objective 1.5. In addition to this activity, the staff attorney in Staunton conducted a comprehensive review of SWVMHI's seclusion facilities, policies, procedures, and clinical practices. He had planned to review the final seclusion monitoring policy once changes were completed. However, this is no longer necessary because DMHMRSAS has issued a Departmental Instruction requiring all state mental health hospitals to observe seclusion monitoring procedures which are substantially the same as those SWVMHI agreed to incorporate into hospital policy.

   B. **Discharge Planning.** As described above in Objective 1.3, DRVD began a program to help ensure that persons who are deemed "ready for discharge" are promptly and properly discharged into community based settings. DRVD began formal investigations of four Community Service Boards, which are responsible for conducting predischarge planning for patients who are "ready for discharge." DRVD demanded that the CSBs give DRVD a list of all of their clients who are deemed "ready for discharge." Of the four, two provided the lists; two refused. Prior to the end of the fiscal year, DRVD prepared litigation against each of the two noncompliant CSBs. In another aspect of this work, DRVD compiled a list of approximately 80 persons who were deemed "ready for discharge" and presented it to the Commissioner of DMHMRSAS. The Commissioner entered an agreement that DMHMRSAS would become involved in the discharge planning and expedite, if possible, the discharges of those persons, and any other "ready for discharge" persons identified by

DRVD. To date, many of the persons identified by DRVD have been discharged.

In separate efforts, DRVD entered into agreements with Eastern and Western State Hospitals that they would forward information regarding DRVD to any person who had been deemed "ready for discharge" who had not been discharged within 90 days of being so deemed. This will allow patients, who may not be aware of DRVD's services, to contact DRVD for discharge planning assistance.

C. **Medication and Other Consumer Rights in Community-Based Facility.** A PAIMI Attorney had a neglect case involving a community-based facility , which he was able to resolve on both the individual and systemic levels. In that case, a CSB's outpatient clinic interpreted the DMHMRSAS October 2000 Priority Populations Checklist to allow it to stop providing certain otherwise eligible outpatient consumers with psychiatric services and medication. The clinic acted on its interpretation, issuing notices to that class of patients to advise them that the clinic would no longer provide them their medications. This action put some of those consumers at imminent risk of destabilization. The PAIMI attorney intervened, successfully instructing, persuading, and negotiating with CSB administrators to have the notices rescinded. Within 24 hours of the PAIMI attorney's intervention, the CSB had not only agreed to restore service to the class of consumers, but had also asked DRVD to provide consulting services to help the CSB come into compliance with all applicable abuse/neglect and consumer rights laws and regulations. The PAIMI attorney referred the CSB to the PAIMI Managing attorney for provision of the requested consultation services.

D. **Rights Training for patients.** A PAIMI staff attorney negotiated agreements with two state hospitals for the PAIMI attorney to conduct monthly rights clinics for the patients. Under these agreements, rights clinics were held on two wards at each facility per month. Ward rotation schedules were set up and followed to ensure that rights clinics were available to all patients of the affected hospitals. At least 109 patients participated in the rights clinics over the six months in which formal clinics were held. Additional patients were served peripherally to the clinics themselves. The patient populations served averaged about 220 individuals (approximate combined average census of the two hospitals). The clinics were conducted to inform patients of their rights and of the availability of DRVD services, and to develop within the patients a sense that DRVD would support them and vindicate their rights. Before the clinics were conducted, many of these patients did not know what rights they had in the institution, or that DRVD services were available to advise, refer, advocate for, and legally assert those rights. Measured in terms of services requested and performed, the clinics have been overwhelmingly successful and have resulted in numerous additional individuals contacting DRVD to apply for services.

E. **Personal rights/freedoms.** A PAIMI staff attorney worked with and monitored the administration of one hospital in a perimeter security project. When this project is complete, the perimeter of the patient area of the hospital will be secured, thus eliminating the need for many of the now extant interior locked doors. When the project is complete, most patients will have greatly increased freedom to move about freely between their wards and other patient areas of the hospital. This project is ongoing, and is expected to be completed during FY 2002. The project will affect most of the patients moving through this 100-200 bed state hospital.

2. **Investigation (other than death).**

A. **Systemic Investigation**. A PAIMI attorney was approached by an informant who reported diversion of federal and state funds by CSB administrators. The informant reported that the diverted funds were grant monies, which had been designated for housing and residential placement of persons with mental illness. The informant provided documents to substantiate his claim, and the PAIMI attorney began an investigation. The investigation is ongoing. More than 500 individuals with mental illness are potentially affected.

B. **Abuse/Neglect Investigation.** As reported earlier, a female with mental illness in her 40s and a female with mental illness approximately 20 years old were the clients. DRVD received critical incident reports from a state mental health facility regarding two alleged rapes at CSH occurring within a month in the same ward and on the same shift. The first attack was not substantiated by the evidence, but there was evidence to support the second report. DRVD staff investigated the incident and reviewed the hospital's internal investigation process. The perpetrator was charged with forcible sodomy, but for reasons unknown to DRVD, this charge was ultimately dismissed before going to court. The DRVD staff attorney conducted an investigation and attended criminal proceedings. She mailed a Notice of Claim on their behalfs to preserve their right to file a civil suit. Systemically, the hospital policy regarding room assignments and overnight supervision was changed in response to these two incidents. All female patients are now placed in rooms closest to the nurses' station and there is a staff member stationed in the hallway outside these rooms at all times during sleeping hours. Both cases are now closed.

C. **Monitoring Services in Facilities**. There were a total of 365 critical incident reports in mental health facilities this fiscal year which DRVD reviewed as part of its monitoring activities. Staff conducted preliminary inquires on 28. Four were converted to case level advocacy with three of those converted to full investigation status. Twenty-four were closed with no further action. Case examples were provided above under the description of this priority.

SECTION VI. NON CLIENT DIRECTED ADVOCACY ACTIVITIES

A. Individual Information and Referral (I & R) Services: Provide total number of I &R services. Refer to the Glossary for the definition of "Information and Referral."

Total Number 2,804

B. Education, Public Awareness Activities And/or Events.
List public awareness activities or events and the number of individuals who received the information. Refer to the Glossary.

1. Number of Education/Training Activities Undertaken 25

Topic	Date	Audience	Number in Attendance
Overview of Existing Human Rights Regulations and Proposed Changes	12/05/00	Central State Hospital, Bldg. 96	12
Education/Focus Group on Human Rights Regulations	12/07/00	Northern Virginia Mental Health Institute in coordination with Northern Virginia Mental Health Association	16
Education/Focus Group on Human Rights Regulations	12/08/00	Western State Hospital, Treatment Mall	50
Overview of DRVD and the Human Rights Regulations	01/18/01	Eastern State Hospital, Patient Council	10
Patient Access to Records and Record Correction	01/24/01	Central State Hospital, Bldg. 96	18
Overview of DRVD/Rights under PAIMI	03/08/01	Danville/South Boston AMI	18
What DRVD Can Do For You-Rights Protection	03/14/01	Powerhouse of Galax and Friendship House of Smythe/ Washington	31
Overview of DRVD/Rights Protection and Focus Group	03/22/01	Central State Hospital, Bldg. 96	25
Overview of DRVD/Rights Protection and Focus Group	03/29/01	Eastern State Hospital, Patient Advisory Council	10
Patient Rights Clinic	04/13/01	Acute Patients, Ward C and Ward D, Southwestern Virginia Mental Health Institute (SWVMHI)	25
Patient Rights Clinic	04/20/01	Admissions and Short-Term Patients, Ward F, Southern Virginia Mental Health Institute (SVMHI)	14
Overview of DRVD/Rights Protection and Focus Group	04/14/01	Opportunity House, Portsmouth	46
Patient Rights Clinic	05/18/01	Ward G and H, SVMHI	6
Your Rights in Discharge Planning	05/31/01	Southwest Virginia Mental Health Institute	19
Patient Rights Clinic	06/05/01	Adolescent and Unit J Patients, SWVMHI	8
Mental Health Human	06/14/01	DRVD Mental Health Human	50

Rights/Various Topics		Rights Conference	
Patient Rights Clinic	06/26/01	High Functioning and NGRI Patients, SVMHI	20
Patient Rights Clinic	07/20/01	Unit E and F Patients, SVMHI	20
Patient Rights Clinic	07/26/01	Unit E (Long-Term) and Unit G (Forensic) Patients, SWVMHI	20
Patient Rights Clinic	08/07/01	Unit G and Unit H Patients, SVMHI	20
DRVD, Who We Are, What We Do—Rights Protection	08/16/01	Northern Virginia Mental Health Institute	3
Patients Rights: Medication and Informed Consent to Treatment	08/21/01	Unit C and D Patients, SVMHI	14
Managing the Financial and Legal Challenges of Having Children with Disabilities, DRVD Rights Protection	08/24/01	Pre-Paid Legal Services Conference for Families of Children with Disabilities	40
Ready for Discharge	09/14/01	Northern Virginia Mental Health Institute	3
Patient Access To and Correction of Patient Records	09/28/01	Eastern State Hospital, Bldg. 24	24

[Total number of training programs sponsored by the P&A or the number of events sponsored by another organization where P&A staff were trainers. The training must have provided specific information to participants regarding their rights. If the P&A only provided general program information report the number of individuals trained in B. 2.]

2. Total number of persons trained (approximate) 522
   [This number should include only those individuals who attended a training program].

3. Information Dissemination Activities — Outcome — # of Items

   a. radio/TV appearances _____ 0
   b. newspaper articles (attach select articles) _____ 2
   c. PSAs/videos/films/etc. aired _____ 0
   d. reports disseminated _____ 0
   e. publications disseminated _____ 5054
   f. Information about P&A disseminated _____ 5928
   (include general training /outreach or presentations not included in training activities)
   g. Number of hits on Website Unknown
   h. Describe other media activities: DRVD produced new promotional materials, which are distributed at events where DRVD has an exhibit. New promotional materials include logo pens, pencils, jar openers, key rings, tape measurers, stadium cups, magnets, and notepads. This initiative was taken to keep our name and contact information readily available.

OUTCOME STATEMENT
For each area of non client advocacy activity, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column above. A. Persons who received information about the P&A and its services **5,928** B. Persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self advocates **522** C. Other outcomes as a result of P&A involvement _____

[Data reported in **Section VI** should assist in developing the above outcome statements.

SECTION VII. OTHER SERVICES AND ACTIVITIES

A. List groups (e.g., State Departments of Mental Health, other advocacy organizations, organized groups of recipients/former recipients of mental health services or family members of such individuals) with whom PAIMI worked cooperatively on activities:

1. Department of Mental Health, Mental Retardation, and Substance Abuse Services
2. Mental Health Planning Council
3. National Alliance for the Mentally Ill-Halifax Chapter
4. Virginia Institute for Developmental Disabilities
5. Valley Community Services Board
6. Department of Juvenile Justice
7. Nottoway County Adult Protective Services
8. Mt. Rogers Community Services Board
9. Friendship House
10. Tatirh Justice Center
11. Department of Rehabilitative Services
12. Department of Medical Assistance Services
13. Advisory Council for Services to the Deaf, Hard of Hearing, DeafBlind, and Late-Deafened in Virginia
14. Virginia Coalition on Juvenile Justice
15. Department of Social Services Adult Care Residences Advisory Committee
16. Virginia Public Guardian and Conservator Advisory Board
17. Local Human Rights Committees
18. Coalition for Students with Disabilities
19. Virginia Board for People with Disabilities
20. State Special Education Advisory Committee
21. The Autism Program of Virginia

B. Describe outreach programs to increase the numbers of minority clients and educate minority constituencies about the PAIMI Program.

No specific minority outreach activities other than those listed under public awareness were undertaken with the exception of ongoing monitoring of the minority caseload to ensure that minority populations were proportionally represented in the caseload. DRVD's established

targets of 20-25% were met. Of the 146 client served this year, 46 were minorities, a total of 32 percent. According to the 2000 Census, the percentage of minorities in Virginia's population is 29.8%. Based on this percentage, DRVD has not had to implement any specific minority outreach activities.

With respect to its Advisory Council, DRVD continued to work with its Advisory Council and staff to increase the number of members on Council and ensure diversity. Efforts to increases Council membership had been successful, but this year, the agency lost several Council members. Two moved out of state and two left to pursue full-time schooling. The nominations committee for the Council is working to increase the membership and the diversity of membership.

C. Did your activities result in an increase of minorities in the following categories?

staff	yes____ or	no__X___
advisory council	yes___or	no__X__
governing board	yes____ or	no N/A
clients.	yes___or	no__X_

D. PAIMI Program Implementation Problems:

1. External Impediments:
Describe any hindrances encountered in implementing legally mandated PAIMI activities (e.g., denial of access to clients, facilities or records; lack of cooperation or resistance from service provider agencies):

Virginia has no statutes which provide a right to community mental health treatment. The only mandated services are emergency services (pre-screening for commitment) and collaboration with state hospitals on discharge planning. Therefore, there is no state statutory support to force development of community placements or the services necessary to support persons with serious mental illness in those placements.

Resistance by service providing agencies to responding to certain DRVD requests for records or other information, despite the requests clearly being within the authority of the PAIMI program resulted in time delays with respect to certain activities and/or investigative work.

2. Internal Impediments: Describe any problems experienced in attempting to implement activities identified as objectives or priorities (e.g., lack of staff time or funds; lack of necessary expertise):

In at least one investigation, the agency could not find a competent medical expert. This resulted in extensive delay and ultimately the closure of the investigation without a finding. No other internal impediments other than extensive workload of PAIMI staff, in part as a result of the addition of the critical incident review, analysis, and preliminary investigative work based on these incidents.

E. Most Important Accomplishments: Please identify what you feel were the PAIMI program's most important accomplishments in this fiscal year:

1. There has been a significant reduction in the number of state hospital patients whose appropriate discharges are delayed more than 30 days after they are found clinically ready for discharge. This has been accomplished through a variety of means including individual casework, education/instruction of hospital and CSB staff/administrators, liaison and intelligence gathering information, negotiations between the DRVD management staff and DMHMRSAS and cooperation/interaction with other groups seeking to promote prompt and appropriate discharges. Specific detail regarding agreements with DMHMRSAS and individual state hospital and the community services board discharge project underway by DRVD have been discussed in detail in earlier sections.

2. DRVD received and reviewed a total of 365 critical incident reports (CIRs) in MH facilities during FY 2001. Staff conducted preliminary inquiries on 37 incidents. Twelve of these were converted to full investigation status. Twenty nine were closed with no further action required. In addition, the critical incident spreadsheet was converted into a Microsoft Access 97 database. While technical in nature and not directly client related, this conversion will improve services to clients. The new database will allow DRVD to track critical incidents based upon several parameters, including day and month of incident, facility where incident occurred, type of incident, time of day of incident and whether the person involved had been in a previous critical incident. Specific trend analysis will be much easier to conduct and enable DRVD to focus more on identifying systemic issues.

3. DRVD continues to complete abuse, neglect, and death investigations and to monitor investigations done by the facilities. These efforts and efforts at studying/monitoring seclusion and restraint practices have resulted in improved safety and protections for consumers residing in the relevant facilities.

4. DRVD entered into settlement agreements with two private hospitals with respect to the issue of forced medication absent informed consent and/or a court order. The Arlington county Circuit Court granted a DRVD motion and held that a hospital must follow the requirements of the Code of Virginia prior to forcing treatment or medication upon patients. The settlement agreement with second hospital was based on presentation to the precedent established in the first case.

5. DRVD negotiated agreements with Central State and Eastern State Hospital to share DRVD materials (1) in admission packages for new patients; (2) in training for staff; and (3) with new forensic admissions and social workers. DRVD brochures on seclusion and restraint, discharge planning and medication are used by these hospitals in ongoing medication and community reentry groups. In addition, an agreement was negotiated with Southwest Virginia Mental Health Institution, in which DRVD materials will be placed in the training and reference materials which all nursing staff are required to read and sign off on during orientation and annually thereafter. Under the same agreement, DRVD materials will be placed in all patient "Green Books" (individual binders containing informative and workbook materials which consumers are given upon admission to the hospital and which they use frequently). All of these agreements ensure increased access to critical rights information for residents of mental health facilities, their families, authorized representatives, and staff.

6. DRVD raised awareness of the public comment process on the pending DMHMRSAS

human rights regulations by holding focus groups and clinics at state hospitals and by mobilizing interested persons through encouraging and assisting patients, families and interest and consumer groups to participate in the regulatory development process. DRVD provided legal analysis and policy input from a patient rights perspective and were successful in getting most of the agency's comments incorporated into the final draft of the regulations.

F. Technical Assistance Recommendations: List Recommendations for future PAIMI Program Federal Technical Assistance Activities.

None at this time.